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REPORT ON ALCOHOLISM IN THE STATE OF MARYLAND

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Maryland Commission on Alcoholism

February 10, 1961
Baltimore, Maryland

Maryland Commission on Alcoholism

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PART A. INTRODUCTION AND GENERAL CONSIDERATIONS

I. AUTHORITY OF THE COMMISSION

By an Act of the General Assembly the Maryland Commission on Alcoholism was created for a period of one year from July 1, 1960, through June 30, 1961, inclusive.[1] In part, the Act stated that:

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> Alcoholism is hereby recognized as an illness and public health problem affecting the general welfare and economy of the State. Alcoholism is further recognized as an illness subject to treatment and recovery and the sufferer of alcoholism is recognized as one worthy of treatment and rehabilitation. The need for proper and sufficient laws, facilities, programs and procedures within the State of Maryland for the control and treatment of alcoholism is hereby recognized.
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> 4. (a) The Commission shall have authority and power to study and investigate the problem of alcoholism within this State, including but not necessarily limiting itself to: (1) present statutes, practices and procedures for the committal, both voluntary and involuntary, of alcoholics, both acute and chronic; (2) present methods of and facilities for the treatment of acute and chronic alcoholics. . .
>
> The Commission shall cooperate with and receive the cooperation of other State agencies, departments, boards, and commissions in effectuating the purposes of this Article.
>
> (b) It shall be the duty of the Commission to submit a report to the Governor and to the General Assembly on or before January 1st, 1961, setting forth the results of its studies and its recommendations, if any, for legislation.

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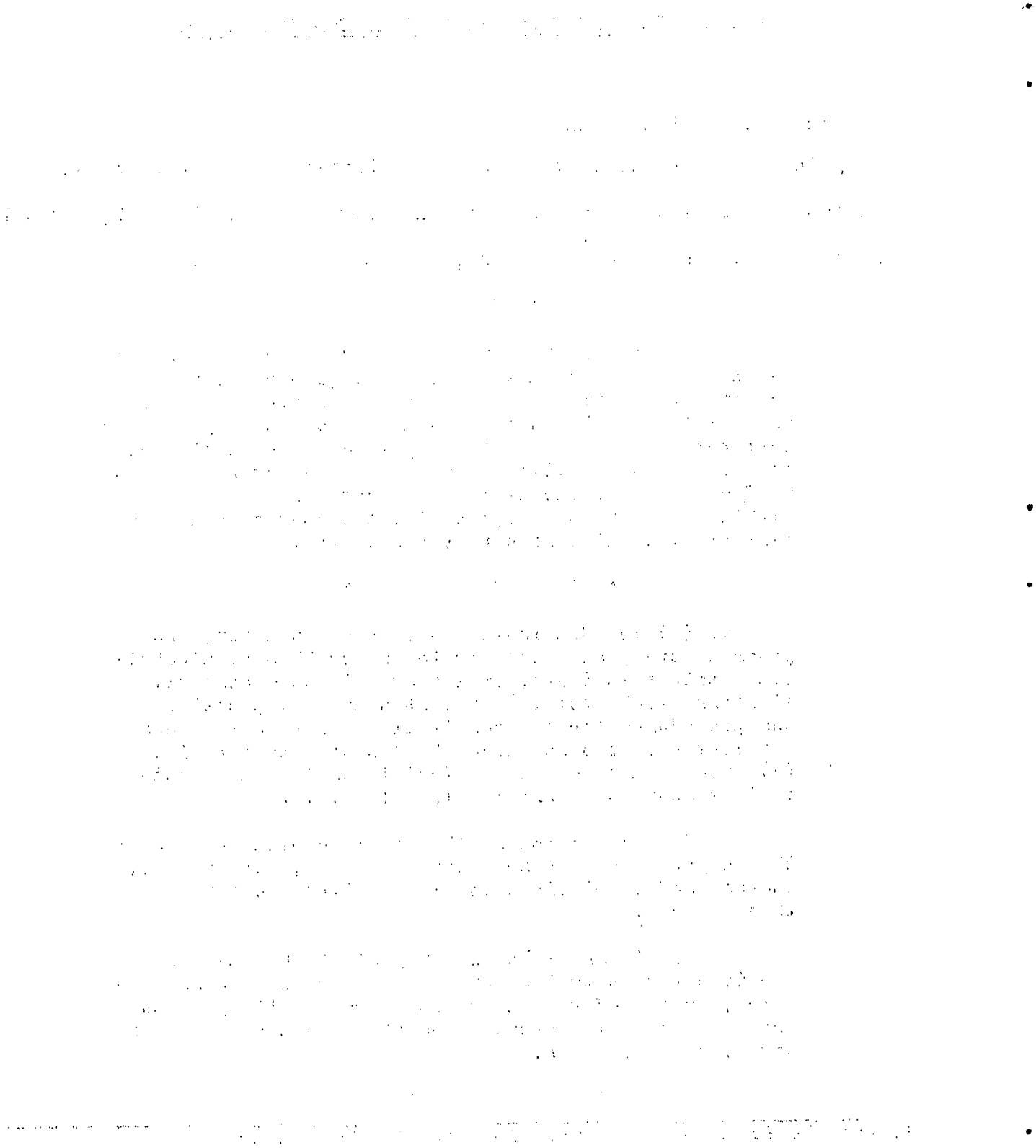
1. Article 2c, Annotated Code of Maryland (1957 Edition)



II. HISTORY

By July 8, 1960, Professor Harrison M. Trice, Ph.D., had been engaged as expert consultant to the Commission. Dr. Trice, who had performed similar work in the past in other states and who is nationally recognized for his contributions in this field, began actual work with the Commission on August 8, 1960. Soon thereafter, two research associates were employed, Mr. Howard M. Bubert, Jr., LL.B., who assumed his duties on September 1, 1960, and Miss Lillian M. Snyder, M.S.S., who began work on August 15, 1960. In general, Mr. Bubert, a lawyer, concentrated on the judicial, law enforcement, penal, parole and probation areas, and Miss Snyder, a psychiatric social worker, devoted herself to the medical and psychiatric areas of investigation. Dr. Lewis P. Gundry, Chairman of the Commission, also operated as the Executive Director.

Dr. Trice spent a considerable amount of time in Baltimore during August and early September organizing the activities of the Commission and its staff. After this initial period, his time in Maryland was limited to visits of two or three days' duration every two or three weeks. However, it was not until mid-October that a secretary was hired and the time-consuming problems of office space and furniture largely resolved.

This left only about three and one-half to four months for the actual performance of the investigative and study duties of the Commission exclusive of compiling the report. Although this extremely limited period of time has been inadequate for the Commission to complete the duties assigned to it, it has been possible

to acquire a good insight into the problem of alcoholism in Maryland.

III. DEFINITION OF ALCOHOLISM USED BY THE COMMISSION

Perhaps because there is no all-encompassing biochemical definition, there are in use today almost as many definitions of alcoholism as there are individuals and groups working with the problem. In addition, there is considerable controversy over whether alcoholism is an independent syndrome and diagnosable as an illness in its own right or whether it is merely secondary and, as such, symptomatic of some more basic, underlying disorder.

The Commission has endeavored to steer clear of this controversy and has, of necessity and in the interest of uniformity in its efforts, chosen its own working definition. This definition rests upon observed social characteristics of a deviant and recurrent nature. In other words, in accordance with the Commission's definition, if entirely or in part because of the excessive use of alcohol, a person behaves in a manner which deviates from the normal pattern of behavior and if, whenever alcohol is used, these deviations consistently recur, then such a person is an alcoholic and is suffering from alcoholism.

This would include the person in the mental hospital diagnosed as suffering from alcohol addiction as well as the patient similarly situated and diagnosed as suffering primarily from a mental disorder and secondarily from alcoholism. It would also include the housewife who, because of excessive use of alcohol, consistently and recurrently neglects her domestic duties and her family to such an extent and in such a manner that this neglect constitutes a deviation from the normal pattern of behavior. Similarly, the individual who repeatedly comes before

the police court for offenses involving or arising out of the excessive use of alcohol may be suffering from a basic personality disorder; but he is still an alcoholic within the framework of the Commission's definition.

It should be pointed out that it was impossible to use this definition in all cases since many agencies use their own definitions and keep their records accordingly. Of course, in these instances the Commission used the definition of the agency involved.

IV. EXTENT OF THE PROBLEM IN MARYLAND

A. Methods of Determining Prevalence of Alcoholism. There are two methods presently available for determining the number of alcoholics in a population, and both methods have their drawbacks. However, in areas where both have been used, the results from each have been quite similar.

One of these methods consists of making actual house to house field surveys of carefully selected, representative samples of the population. This has various limitations, some of which arise out of people's natural reluctance to discuss the problem of alcoholism and their tendency to cover it up. In any event, lack of time and money prevented the Commission from even considering such an approach.

The other method available for determining the number of alcoholics in Maryland was the Jellinek Estimation Formula.* Without going into detail, suffice it to say that by the use of this Formula it is possible to estimate fairly accurately the number of alcoholics in a given population by correlation with the number of cirrhosis of the liver deaths in that population during a given period of time. This was the method used by the Commission.

*See Appendix I

Although in recent years the complete statistical validity of the Formula has been subjected to criticism, as was pointed out above, where independent studies have been conducted in addition to the application of the Formula, the results have been fairly close. The Commission has been conservative in arriving at the estimates resulting from the use of the Formula and would like to point out that these estimates of the prevalence of alcoholism are sufficiently accurate to permit planning for a large scale unit such as the State of Maryland.

B. Prevalence of Alcoholism in Maryland. In any study of alcoholism in Maryland several points obtrude. First, Maryland stands high in alcoholic population among the South Atlantic States. In 1948 it ranked first, and in the ensuing years its rank has varied between second and third place. Speaking very conservatively, it is possible to say that during these years the alcoholic population of Maryland has fluctuated between 50,000 and 100,000. These figures are large when compared to the figures for adjacent states.*

One of the reasons for this large alcoholic population is the presence within the State of Baltimore City and the counties adjacent to Washington, D. C., which go to make up the greater metropolitant area of that City. And this brings us to the second point which is that, according to the best evidence available, Baltimore City contains some 40% of the total alcoholic population of Maryland. Also, it is quite probable that Baltimore County has a large alcoholic population, especially in the populous areas situated near or immediately adjacent to the City. Together these two areas contain more than half of the alcoholic population in the State.

*See Appendix II

Third, although it is generally true that in Maryland the greater the population in a given area the more alcoholics there are, the rate of alcoholism prevalence does show a marked and as yet unexplained increase in certain counties, notably Kent, Queen Anne's, Charles and Allegany. Otherwise, it appears that the majority of the alcoholic population is concentrated in Baltimore City, Baltimore, Anne Arundel, Prince George's, Montgomery and Washington Counties.

Fourth, according to the Jellinek Formula, there were 76,7000 alcoholics in the State in 1959.

V. AN APPRAISAL OF THE EXTENT OF THE PROBLEM

A. General. Alcoholism currently presents the fourth most widespread national health threat, ranking only after heart disease, cancer and mental illness. Unfortunately, however, with the mention of statistics such as the ones just cited most private and public individuals and institutions concerned with medical and psychiatric care immediately envision a great flood of alcoholics descending upon them. The prospect of being inundated by 76,7000 highly intoxicated, violent, belligerent and hopeless skid row drunks, many of whom are suffering from delirium tremens and similar complications is, to say the least, not a reassuring one. Fortunately, however, this picture is also extremely erroneous. Should the treatment facilities, such as general hospitals, presently available in this State open their doors to alcoholics, there is little possibility they would be deluged either now or at any time in the near future.

Actually, one of the great problems involved in treating alcoholism stems from the alcoholic's extreme reluctance to seek treatment.

Nor are there probably more than three or four hundred alcoholics at any one time in the State who are in the acute stage of the illness, and it is only in this stage that there is a need for emergency, medical treatment. Normally, alcoholism remains arrested most of the time.

B. The Acute Phase of Alcoholic Intoxication. A person suffering from acute alcoholic intoxication may or may not be an alcoholic. Sufficient quantities of alcohol consumed over a short period of time act quite literally as a poison and can be fatal if not treated promptly and adequately. An acute alcoholic is simply an alcoholic suffering from acute alcoholic intoxication.

Moreover, the acute phase, although requiring prompt and even emergency medical treatment, can be brought under complete or almost complete control within a relatively few hours if such treatment is provided.

As was pointed out above, episodes of acute alcoholic intoxication are infrequent, and at any given time in Maryland only an extremely small number of persons are suffering from this.

C. Three Types of Alcoholic. Although there are many ways of classifying alcoholism, probably the most useful method for a survey of this kind is to group them by the manner in which they are or are not affected by the law. One segment of the alcoholic population by reason of its behavior violates the criminal laws; another, because of pronounced mental disorders, becomes or may become subject to the laws governing the insane; and, finally, a third group does not by reason of excessive drinking become affected by the law.

Under this method of classification there is, first, the group

which roughly falls into the category of the chronic police court inebriate. These are the people who are arrested for various criminal violations but who, for the most part, are arrested fairly repeatedly for such minor offenses as drunkenness, assault, disturbing the peace, disorderly conduct, vagrancy and begging. Although the persons in this group are most noticeable, most publicized, and are a vexing community problem, the fact remains that, unless Maryland is quite different from the rest of the country, they make up only 3% to 7% of our total alcoholic population. They are extremely unresponsive to treatment.

The second segment is that composed of alcoholics suffering from accompanying mental disorders which are sufficiently obvious and of a type to render the victim commitable to a mental institution. This group is also relatively small, comprising approximately 20% of the total alcoholic population.

And then there is the third segment of the alcoholic population whose members have not come into contact with the law enforcement agencies and who are not suffering from mental disorders of a sufficient seriousness or of a type which allow for their commitment to a mental institution. It may be that their mental disorders are undetected or it may be that they are suffering from no mental disorders at all. At any rate, they are alcoholics and they are not eligible for commitment or arrest. Most of the persons in this group hold jobs, and many of them are in highly placed executive and professional positions. Not infrequently the fact that they are alcoholics is either unknown by their associates and friends or is merely suspected by a few persons such as the members of their immediate family. Hidden in this segment

is an undetermined but large number of female alcoholics.

It is this third group that forms the great bulk of the alcoholic population, i.e., about 75%. They are for the most part in the early and middle stages of the disease and do not yet exhibit the dramatic and bizarre behavior that is usually associated with full-blown alcoholism. Their disorder has, in many cases, not disrupted their life, although the first signs of disruption may be clearly evident. This is the group that is most responsive to treatment. It is also the group toward which the Commission should quickly direct its major efforts.

VI. PAST ACTIVITIES IN MARYLAND*

Concern for the alcoholic is not new in Maryland. For example, over one hundred years ago the Maryland Inebriate Asylum was incorporated to receive and retain all inebriates. Slowly during the intervening years an objective, scientific approach to alcoholism evolved. This tendency has increased in recent years.

During the past three decades a substantial amount of work on alcoholism has been done in Maryland. These studies and activities have occurred in isolated units with little or not relation to each other. They have been carried out by private individuals, by agency-sponsored groups, and state-wide commissions.

Individual studies have been made on the effect of alcohol on the brain, comparative value of tranquilizers in treatment of the acute stage, conditions under which alcoholic patients seen in psychiatric outpatient clinics improve, attitudes toward group psychotherapy, results of group psychotherapy, and various descriptive studies.

*See Appendix III

The agency-sponsored studies aimed, in the main, at clarifying the role of specific agencies in the management of the alcoholic were relatively successful. The agencies concluded that the alcoholic was typically misplaced as far as specific agency management was concerned. They came to realize the complexity of the problem. Their activities and reports underscore the inadequacy of the present law. In addition these studies spelled out practical next steps to be taken. A prominent example is the Northwest Community Project. Here effective counseling procedures with police court inebriates were demonstrated and a pattern for future action developed. Unfortunately, however, none of these recommended next steps were carried to completion.

In the late 1940's two state-wide Commissions on Alcoholism sent out questionnaires to all magistrates in the State and invited representatives of the Department of Mental Hygiene, State Aids and Charities, Maryland Anti-Saloon League, Baltimore City Council, Laurel Nursing Home, Alcoholics Anonymous, general hospitals and nationally known consultants to express their views. As a result a bill was introduced in the General Assembly to creat a Commission on Alccholism, to establish two alcoholic rehabilitation clinics in Baltimore City, one of the Eastern Shore and one in Western Maryland and to make studies on care and treatment of alcoholics, and to make periodic reports to the Governor and General Assembly with recommendations for additional legislation if needed. Governor Lane vetoed the bill, saying: ". . . As desirable as the objective of the Bill may be there is no sufficient reason why the expenditures of State funds under its provisions should not conform to established rules and requirements."

Three years later Governor McKeldin, by executive directive, established the Section on Alcohol Studies under the Division of Mental Health, within the Bureau of Preventive Medicine in the State Health Department for the "study and research, education, and assistance in treatment of the alcoholic." Within three years six alcoholic rehabilitation clinics were organized, each operating three hours per week, within the county health departments. Also a pilot demonstration program was set up in the Northwestern Police District Court. Many researches and educational programs were sponsored by the Section on Alcoholism during its five-year existence.

All of these activities represented many professional viewpoints and efforts. Participants came from such diverse groups as lawyers, physicians, sociologists, psychologists, social workers, teachers, and clergymen.

In conclusion, much has been done on many fronts by many individuals and groups, but little has been accomplished to effectively rehabilitate the alcoholic.

The main lack appears to be the absence of follow-up studies to ascertain the effectiveness of these scattered efforts and the failure to support those programs which were successful. Probably the overriding feature of these past studies has been the lack of any effective coordination of all these loosely organized, yet substantial endeavors.

VII. STATE LAWS IN MARYLAND DEALING WITH ALCOHOLICS

Although the Commission has extracted and listed all of the Statewide laws pecularly applicable to alcoholics and although at this time certain marked deficiencies seem to exist in the statutes, the Commis-

sion has not as yet had sufficient time to make a thorough study and evaluation of them.* Furthermore, it is the opinion of the Commission that no truly intelligent over-all study and appraisal of the statutes affecting chronic and acute alcoholics can be made until the investigation of the problem in general has been substantially completed, since only then will statutory inadequacies become readily apparent. Certainly no sound recommendations could be made before the Commission has had an opportunity to fully explore the entire problem.

PART B. LEGAL INSTITUTIONS AND LAW ENFORCEMENT AGENCIES

VIII. SCOPE AND PROCEDURE

This section of the report deals with that part of the State survey directed at those agencies, departments and institutions engaged in or primarily engaged in law enforcement and the administration of justice. Broadly speaking these include the following:

1. Police
2. Jails
3. Courts
4. State's Attorneys' Offices
5. Probation Departments
6. Court Medical Examiners
7. State Penal Institutions
8. State Parole Board
9. Department of Motor Vehicles

The investigations were directed at learning the procedures and facilities available and actually used in handling and dealing with alcoholics and were also directed at learning the number of alcoholics with whom these agencies deal. Although lack of time probhibited all sources being surveyed throughout the State, the following representative sources of information and data were actually studied and/or

*See Appendix IV

investigated:

1. The Department of Motor Vehicles
2. The Department of Maryland State Police
3. Police Bureau of Baltimore County
4. Police Department of Baltimore City
5. Office of the State's Attorney for Baltimore City
6. Office of the State's Attorney for Baltimore County
7. Traffic Court of Baltimore City
8. Trial and Police Magistrates
9. Office of the Medical Examiner to the Supreme Bench of Baltimore City
10. The State Department of Parole and Probation, The Parole Board
11. The Probation Department of the Supreme Bench of Baltimore City
12. Probation Department of Baltimore County
13. The Baltimore City Jail
14. The Department of Correction--The Maryland House of Correction

No priority was given to these originally because it was not known which ones, if indeed any of them, would prove fruitful sources of information and data.

IX. ABSENCE OF PROCEDURES, FACILITIES AND USEFUL DATA

The agencies and departments surveyed have neither facilities nor procedures for handling alcoholics. Neither do they have any means of classifying or identifying alcoholics or persons with drinking problems aside from the sort of hit or miss personal recognition that may come from repeatedly seeing an individual.

The reason is obvious. These agencies are dealing primarily with crimes and the perpetration of crimes. Alcoholism is not a crime; and so, with but few exceptions, the alcoholic or incipient alcoholic who comes into contact with the agencies in question does so only because he violated the criminal law. If recognized at all, his alcoholism is in most instances of purely minor importance, an extenuating circumstance at best.

The only criminal statistical categories which even identify

excessive drinking are those of drunkenness and drunken driving. By itself an arrest for and conviction of either offense means little or nothing since conceivably anyone could experience such a misfortune. It is only after a person repeats these offenses that clues as to possible alcoholism are provided. Records are not kept to show the number of recidivists arrested and convicted. Any information desired along these lines can only be obtained by costly and time-consuming searches of the files of the police departments or the Department of Motor Vehicles.

In addition, many persons who are arrested each year for disorderly conduct or disturbing the peace were actually drunk at the time of the offense. However, this fact is not even noted in the records, and these arrests and convictions become statistics under the headings of disorderly conduct and disturbing the peace. Similarly, a man gets drunk and assaults his wife. He is charged with and convicted of assault. This is all that appears on the police records and on the docket of the police magistrate's court, although, from personal and past experience, the magistrate and the arresting officer both know that the man was drunk and has been before and, furthermore, becomes belligerent only when he is intoxicated.

In summation, none of these agencies has any means or methods for identifying and classifying alcoholics, nor do they have any procedures or facilities for handling them nor do they even keep statistics or data in such a way as to reflect the number of alcoholics which appear among the persons with whom they work. Although under such circumstances it is impossible to make any estimate of the cost involved in

handling alcoholics, nonetheless the processing of numerous alcoholics through the courts is costly.

X. BALTIMORE CITY JAIL SITUATION

An excellent study of a large segment of the Baltimore City Jail population was made in 1956 by The Baltimore Council of Social Agencies and entitled A Study of Homeless, Sick and Alcoholic Persons in the Baltimore City Jail.* The findings were essentially the same as those of other studies made of similar groups in other parts of the country. There is every reason to believe that the general situation at the Baltimore City Jail remains the same today, and the President of the City Jail Board has confirmed this. In 1955 there were 17.4% more convictions for the five offenses studied than in 1939. In addition, whereas at the time of the 1956 study Baltimore City police were making approximately 24,000 arrests each year for drunkenness, disorderly conduct, disturbing the peace, vagrancy and begging, in 1959 the arrest total for these categories had climbed to more than 31,000. Many of these offenses either involve or frequently stem from excessive drinking.

The 1956 study found that on any given day, out of a jail population of approximately 1,000, there were some 400 inmates incarcerated for either drunkenness, disorderly conduct, disturbing the peace, vagrancy or begging. During the course of a year some 3,400 individuals passed through the Jail for committing the five offenses mentioned. A small core of these chronic police court inebriates made up a large percentage

*/Baltimore Council of Social Agencies; Edward B. Olds, Research Director/ A Study of Homeless, Sick and Alcoholic Persons in the Baltimore City Jail (Mimeographed report.); Baltimore 1956.

of the Jail work load since on the average they were arrested about five times a year and jailed about four times, mostly because of inability to pay even small fines.

The Report concluded by stating that some 31% of the study population needed long-term, and in many cases life-time, care either in mental hospitals, chronic disease hospitals or nursing homes; approximately 35% needed long-term or life-time care in a "rehabilitation center" or "work-farm" for alcoholics; 12% needed some sort of out-patient care and counseling; and only 17% actually belonged in jail. For the remaining 5% no judgment was made.

The Commission would like to point out that in general these findings are in full accord with other studies made of similar groups in other parts of the country and made both before and after the 1956 Baltimore City Jail Study.

XI. NORTHWEST COMMUNITY PROJECT ON ALCOHOLISM

In Baltimore City, during the period extending from September 1, 1954, through April 30, 1957, a demonstration project was instituted and carried on to provide counseling and social work services to carefully selected persons who came before the Northwestern District Police Magistrate's Court for various offenses but whose main problem seemed to be excessive drinking. The persons ultimately selected for counseling had committed the following offenses: assault, disturbing the peace, disorderly conduct, "found drunk," and larceny.

The project was conducted as a demonstration by the Division of Mental Health, Maryland State Department of Health, and in June of 1958, a Survey of the results was published. At the time of the study

60% of the offenders who had been counseled had had no further contact with the law at all.* This project, both in concept and in results, was most promising. Unfortunately it was not continued.

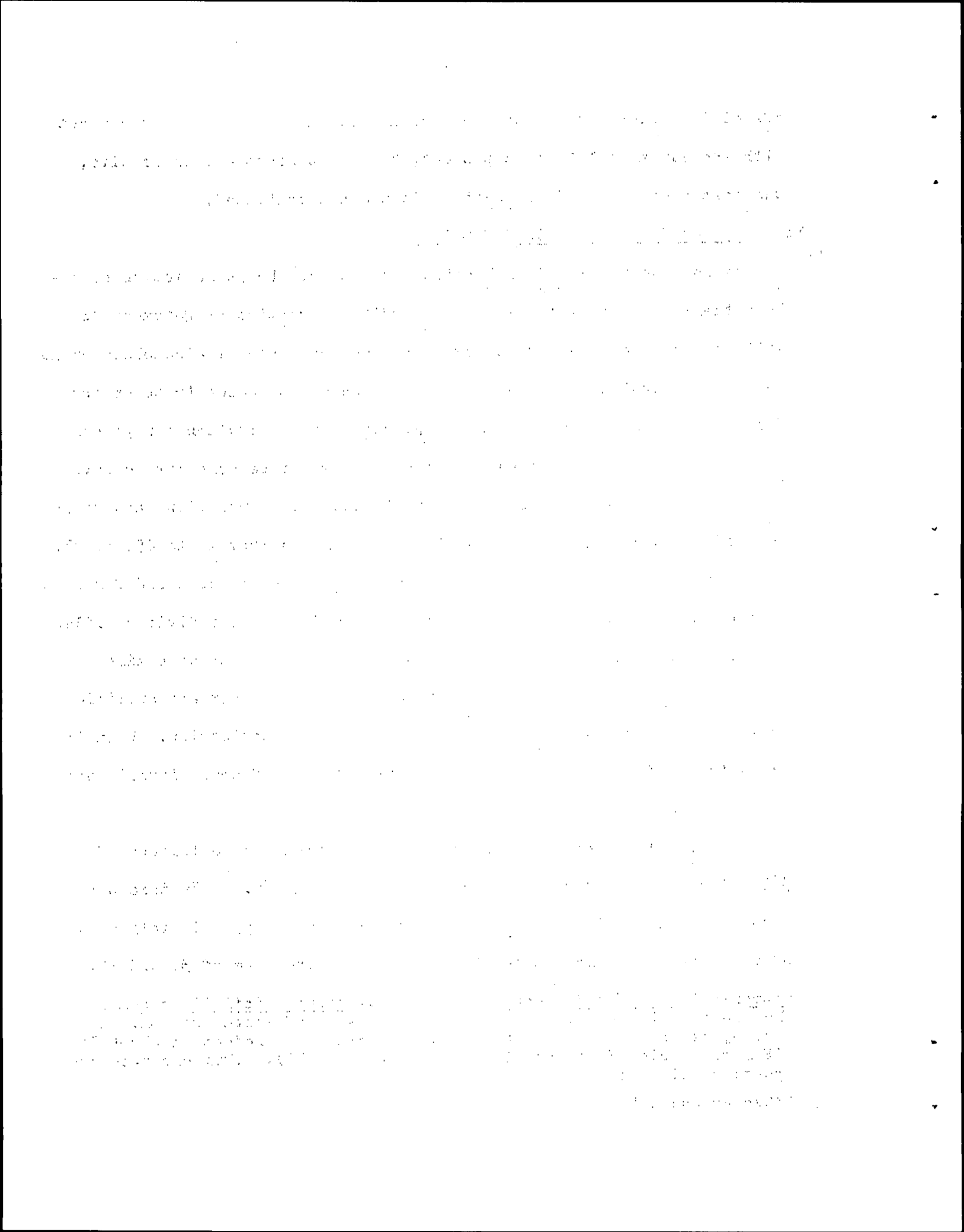
XII. THE MARYLAND HOUSE OF CORRECTION

As is true in all of the institutions under the jurisdiction of the Department of Correction, with the possible exception of Patuxent Institute, no records are kept regarding the incidence of alcoholism among the inmate population. The Commission decided to concentrate on the House of Correction since this medium security institution for persons receiving sentences of three months or more would be more apt to have a high alcoholic and chronic police court inebriate population than would the Reformatory, which is primarily for offenders from 16 to 25, or the Penitentiary, which is for those sentenced for longer terms and for more serious crimes. Accordingly, a survey was made of the individual files of a limited sample of inmates. This was done merely to determine whether or not the individual files contained sufficient and sufficiently uniform information to warrant a further investigation. When it was determined that the information available was of some significance, the survey sample was increased.

Accordingly, a check was made of the individual file folders of 363 white male inmates between the ages of 30 and 60.** In this age group there was a total white inmate population of approximately 447. Of the inmates in the sample who were between the ages of 30 and 44, approximately 35% had records on file indicating a definite alcohol

*Maryland State Department of Health, Division of Mental Health. A Survey of the Baltimore City Northwest Community Project on Alcoholism (For the Period September 1, 1954-April 30, 1957). (Mimeographed report) Baltimore; 1958.

**See Appendix V



problem; while in the 45 to 60 age bracket, about 60% had records indicating a definite alcohol problem. Many of the men in the older age bracket appeared from the records to be typical chronic police court inebriates. The younger men seemed to have more serious criminal records and had, for the most part, been convicted of relatively serious crimes.

XIII. MAGISTRATES' COURTS

Although the courts presided over by the magistrates throughout the State hear almost all of the cases primarily involving excessive use of alcohol, the records kept by these courts are for the purposes of this Commission no better than those maintained by police departments. The docket simply shows the charge made by the police and the disposition of the case. Other than in cases involving the specific offense of public intoxication or drunkenness, the part played by excessive drinking is unrecorded. And even in cases of drunkenness the record can be misleading. A dismissal can mean that the defendant was not guilty as charged; or it can mean that, after having "slept it off" overnight in jail, he was let off with a warning.

XIV. CONCLUSIONS

As was pointed out on page 8, there is a small but very obvious segment of the alcoholic population (from 3% to 7%) which is composed of individuals who are repeatedly arrested for minor crimes and who drink excessively. These persons are referred to by many labels, and for the purposes of this report will be called chronic police case or chronic police court inebriates. Although they are popularly regarded as habitués of skid rows in large metropolitan areas, they are also to

be found in rural settings. Their common denominators are repeated arrests and incarceration for minor offenses usually connected with or arising out of fairly continuous excessive drinking, homelessness, unprofitable and menial employment, if any, and almost total unresponsiveness to rehabilitation and/or treatment.

These people make up a substantial portion of the Baltimore City Jail population and an undetermined portion of the population of the House of Correction and the local jails throughout the State. There is almost universal agreement throughout the country that these people do not belong in jail because to put them and keep them there is inhumane, costly and patently unsuccessful. The same individuals continue to be arrested, tried and jailed in a seemingly never-ending pattern.

If nothing else, they should be confined for a relatively long period of time or for an indeterminate period of time to reduce the turnover and processing; they should be placed in a minimum security institution to cut building and maintenance and guard costs; and they should be in a rural setting where they could at least work to assist in supporting themselves by growing some of their own food. In addition, in such a setting, where they would remain for a considerably longer period of time than is presently the case with the 10-to-30-day jail sentences usually handed out, it is possible that they might break the pattern of their existence, although the many studies made of the chronic police court inebriate indicate that the prospect of lasting change is dim indeed. Because of the extreme lack of responsiveness to treatment and rehabilitation exhibited by these persons as indicated in numerous studies and experiments throughout the country, costly and apparently

unsuccessful professional services should not be provided. Instead, the institution or facility to which these people should be sent should be provided with a nonprofessional, mainly custodial and service staff.

In conjunction with this, there should be established counseling services similar to those provided in connection with the Northwest Community Project described on pages 16 and 17 in this report. The services could be set up to operate as adjuncts to the magistrates' courts in the areas having the largest case loads involving chronic police court inebriates. The purpose of such a service should be to attempt to prevent persons from becoming chronic police case inebriates. Only carefully selected offenders should be chosen for counseling because both studies and practical experience in other areas indicate that only a relatively small segment of the persons coming before a magistrate's court can benefit from such counseling and because to do otherwise would be prohibitive from a cost standpoint.

Whether or not chronic police case inebriates are distributed in substantial numbers throughout the State or are primarily a Baltimore City problem is unknown. However, it is felt that, until these persons are provided for in some way, it will be impossible to combat successfully the problem of the hidden or uncommittable alcoholic; and it is this group that is most responsive to treatment and makes up the great bulk of the alcoholic population. It is mandatory that persons, agencies and institutions dealing with the hidden or uncommittable alcoholic be assured that they will not be deluged with chronic police case inebriates. For this reason the Commission is of the emphatic opinion that the chronic police case inebriate population of Maryland is a State

problem.

Finally, the greatest potential source of information on the subject of the chronic police case inebriate is the magistrate's court. Accordingly, one judge of the new Municipal Court of Baltimore City and one--or at the most two--magistrates in Allegany, Anne Arundel, Baltimore, Charles, Montgomery, Prince George's, Queen Anne's, Kent and Washington Counties should be designated to hear all cases of simple assault, drunkenness, disorderly conduct, disturbing the peace, vagrancy and begging. In addition, these magistrates should maintain records showing substantially the information outlined in Appendix VI. These records should be maintained for a one-year period from, for example, July 1, 1961 through June 30, 1962, and each month totals should be made and forwarded to the Commission for analysis and study. Part-time clerical assistance for this purpose should be provided the designated magistrates. In those jurisdictions where this case load is insufficient to require the magistrate's full time, he could, of course, hear other cases. At the conclusion of the year-long survey period the procedure of having one magistrate hear all the alcohol related cases should be continued in those jurisdictions shown to have a large enough chronic police case inebriate population to warrant this.

In the short period of time available to the Commission it has been impossible to arrive at minutely detailed plans and specifications for a facility, procedure and approach to the chronic police case inebriate. For one thing, more information is needed regarding the extent and distribution of such people throughout the State. However, for the reasons outlined, the Commission feels strongly and emphatically that the

problem is a State problem, that it must be resolved before any real headway can be made against the main alcoholism problem in Maryland, that steps toward resolving this chronic police case inebriate problem must be taken immediately, and that the approach and plan outlined above is completely sound in the light of the best available current knowledge on the subject. The Commission should also like to point out that the described plan is aimed at the unresponsive chronic police court inebriate and also at the most responsive type of alcoholic who comes before the police court. This may be a solution to the problem, and, in any event, is a mandatory first step. However, after further study and investigation and after analysis and study of the results of the survey by the designated magistrates' courts, it may well be that a need for some form of intermediate facility such as a rehabilitation center will be indicated. Presumably this would fill a possible gap which may exist between the two groups discussed above.

PART C. PSYCHIATRIC AND MEDICAL AGENCIES

XV. SCOPE AND PROCEDURE

This section of the report deals with that part of the State survey directed at those public and private individuals, groups, agencies, departments and institutions working, for the most part, in the fields of psychiatry and medicine. They fall within the following general categories:

1. Hospitals
2. Clinics
3. Physicians and medical schools
4. Half-way houses and vocational rehabilitation
5. Licensed nursing homes

6. Religious organizations and groups

In investigating within these areas a priority list was set up so that the most obvious and fruitful sources of useful data would be studied first. With each particular possible source of information the investigation was aimed at securing, when possible, the following information:

1. Legal responsibility of the source
2. Names and legal and professional responsibility of individual subunits
3. Definition of alcoholism or alcohol pathology used by source
4. How individuals with alcohol pathology come to the attention of the individual source
5. Admission procedure
6. Labeling process--criteria by which alcoholics and possible alcoholics are classified
7. Background of person doing the labeling
8. Treatment provided
9. Staff organization
10. Goals of treatment
11. Effectiveness of treatment and degree to which goals are achieved
12. Research engaged in and evaluation thereof
13. Possible gaps in the procedure and facilities
14. Number of alcoholics processed
15. Costs involved in handling alcoholics

Although in the time available it was impossible to investigate all of the groups, agencies, departments and institutions in the medical-psychiatric field in the State, the following were studied, in whole or in part:

1. State Mental Hospitals
2. Private Psychiatric Hospitals
3. Psychiatric Outpatient Clinics
4. State Tuberculosis Hospitals
5. State Chronic Disease Hospitals
6. Licensed Nursing Homes
7. Teaching Hospitals
8. General Hospitals
9. State Department of Health Medical Care Program
10. Blue Cross
11. Half-Way Houses
12. Maryland Council of Churches

It should be pointed out that in these areas there is a wealth of information available. Although much of it has been collected for only a short time, there is on hand a small, but ever-increasing body of useful data from these sources.

XVI. STATUTES IN MARYLAND USED FOR COMMITMENT OF THE ALCOHOLIC

Although, as was mentioned on pages 11 and 12, no complete study has been made of the commitment laws as they apply to alcoholics, the Commission would like to point out that in the main these laws are designed for the commitment of the insane to mental hospitals. Without going into what constitutes insanity within the meaning of these statutes, suffice it to say that the overwhelming majority of alcoholics do not fall into this category; and of those who do, many do so for only short periods of time. The result is that many alcoholics are uncommittable and many of the ones who are temporarily committable can easily obtain their release under the present law after a short period of time. To cite just one example, the acute alcoholic who is seeing things and does not know what day it is or what his name is, is committable. When he sobers up and "dry's out" and stops hallucinating and becomes oriented again, he may obtain his release. In addition, a substantial number of alcoholics voluntarily commit themselves to the state mental hospitals and under these circumstances they also may obtain their own release.

This, to a large extent, contributes to the large number of persons who quit treatment programs before they have had any opportunity to benefit from them. It also has a marked demoralizing effect upon hospital staffs.

There are also definite indications that the potentially most responsive segment of the alcoholic population, or at least the large hidden alcoholic segment of that population, is kept from seeking treatment because of the stigma attached to the present methods and procedures for committing alcoholics for treatment.

XVII. MEDICAL AND PSYCHIATRIC DEFINITIONS OF ALCOHOLISM

The Commission does not intend to become involved in the conflicting theories of definition and diagnosis employed by the medical profession. Generally, alcoholic patients are identified under three diagnostic classifications as set forth in the 1952 edition of the Diagnostic and Statistical Manual for Mental Disorders published by the American Psychiatric Association.

It is interesting to note, however, that these diagnostic classifications are subject to rather wide variations in interpretation and application and that these variations exist from one hospital to another and from one unit to another within a givenhospital and from one individual to another within a particular unit. In actual practice, classification depends to a large extent upon the background, training, experience and even prejudices of the person making the diagnosis.

XVIII. THE DEPARTMENT OF MENTAL HYGIENE

A. General. The Department of Mental Hygiene has full and complete powers over and supervision of all matters relating to the custody, care and treatment of the insane. This includes supervision, direction, and control over the State Mental Hospitals. In addition, the Department supervises and licenses all public and private institutions in which mental patients are detained.

Although patients with a history of alcoholism are residing in six of these State institutions, persons actually diagnosed as alcoholics are currently being admitted to only Eastern Shore, Springfield, Spring Grove and Crownsville State Hospitals.

Crownsville admits only negro persons residing anywhere in the State, and the other three admit white persons from only that section of the State which the particular hospital services.

B. Hospitalization from Admission to Discharge at Springfield, Crownsville and Eastern Shore.

1. Admission. Upon arrival at the Hospital the patient is examined to determine whether or not he is in need of physical or psychiatric emergency treatment such as, for example, immediate treatment for a broken leg and acute alcohol poisoning. If such an emergency exists, the patient is sent to the medical-surgical unit or other unit for the care indicated. The diagnostic studies performed on persons suffering from acute alcohol poisoning are extremely thorough, more so than those done in some general hospitals. Patients with positive findings are sent to the medical-surgical unit for additional studies. Intensive, appropriate treatment is provided for those in the acute phase of alcoholism and the program for treatment of this stage is especially well organized at Springfield. Within twenty-four hours after admission, if medically possible, and in conjunction with the above, the physician, who makes the original examination and who is usually a third-year resident or less, makes a diagnosis. During the time the above procedures are being carried out, the patient is "on the admission service" and is, in effect, being processed and made physically ready for the

course of psychiatric treatment to follow. Alcoholic patients usually remain on admission service for from five days to two weeks. Many alcoholic patients after recovering from the acute phase, ask to be and are discharged. In effect, they "dry out" at State expense; and, when physically fit again, leave the Hospital and return to drinking.

2. Treatment. For those alcoholics who do remain for treatment there are a variety of therapies employed. Such patients are transferred to the active treatment units or convalescent areas where, according to individual need as determined by the Staff, they may receive or be included in individual psychotherapy, group therapy and discussions, chemotherapy, occupational therapy (farm work), recreational therapy, psycho-drama, pastoral counseling, social work discussion groups with relatives, predischarge planning, and individual and vocational rehabilitation counseling. A new program of self-government by the patients is believed to have strong therapeutic value.

In these three Hospitals the alcoholic patients are mixed in with the other patients, and outside of organized Alcoholics Anonymous groups in the Hospital and group psychotherapy specifically for alcoholics the various therapies are not specifically designed for and directed at the alcoholic patient.

3. Discharge. The majority of alcoholic patients are discharged outright without either referral elsewhere or follow-up. If the resident in psychiatry or the social worker involved with a case happens to know something about the agency services in the community which might be of help, the patient might be referred to them on

discharge. However, the majority of alcoholic patients are discharged outright without either referral elsewhere or follow-up.

C. Spring Grove State Hospital. Spring Grove follows the same general pattern as do Springfield, Eastern Shore and Crownsville with the following important differences.

After alcoholics leave the admission service, they are transferred to a special section or unit of the Hospital known either as Convalescent Cottage II or as the Alcoholic Rehabilitation Unit. There they live with other alcoholics separate and apart from the other patients in the Hospital. In this Unit, although the same general therapies are used as in the other Hospitals, they are specifically directed at the alcoholic patient. There is also a permanent staff which deals on a full-time basis with only the alcoholic patient. In addition, substantial efforts are made to adequately plan and prepare a patient for discharge. Referrals are made to applicable community services such as Foster Care and the county outpatient clinics. Complete medical and social summaries are forwarded.

Although the Unit has seventy beds and a full-time operating capacity of approximately sixty-five patients, it usually has a population of about fifty patients. In addition, the professional and non-professional staff is inadequate even for this modest load.

At the moment the Commission has in preparation a detailed description of the Spring Grove Alcoholic Rehabilitation Unit.

D. Research. The Research Organization for the Department of Mental Hygiene is located at Spring Grove and is available for consultation and supervision of research activities in all the State Mental

Hospitals. The Department of Medical Research consists of a multi-disciplinary staff representing the fields of psychiatry, neurology, psychology, social work, nursing, electroencephalography, pharmacology, chemistry, electronics, statistics and administration.

The Department is excellent, has done some valuable research which has been published and has numerous other research projects in planning, in progress, and being prepared for publication. In this connection it is interesting to note that although Maryland spent $20,543,948 for the care and treatment of the mentally ill last year, only $119,301 or one-half of a cent out of each dollar so spent went for research.

E. Number of Alcoholic Patients and Costs. The daily average of alcoholic patients in our four Mental Hospitals is 414. Their individual cost is $4.69 per day or $1,941.66 for the total group. These patients represent individuals admitted for the first time as well as returnees.

A total of 621 alcoholics completed their first hospitalization during the year ending June 30, 1959. Complete information about costs is available for 582 of these. Their average length of stay was 65 days. At an average cost of $4.69 a day the total cost for the first hospitalization for each patient amounted to $304.85. Because these patients were not treated successfully during their first hospitalization, they returned from two to three times on an average within five years, thereby greatly increasing the cost of care, the drain on physical facilities, and professional services.

F. Conclusion. There are approximately the same number of alco-

holic patients readmitted during the course of a year as there are patients admitted for the first time. In addition, many of the patients being readmitted have been patients many times before. The readmission rate seems to be highest at Springfield and lowest at Crownsville.* None of the Hospitals has had much success in assisting the alcoholic to achieve sobriety. There is not even complete agreement on whether or not an alcoholic should attempt to drink again. There is almost no follow-up. For all practical purposes there is no evaluation made of the relative success, if any, of the various therapies used. Except for Spring Grove, there is almost no discharge planning.

On the bright side we find the excellent Spring Grove research team and the unique Spring Grove program for a segregated group of diagnosed alcoholics in one place where they can be treated specifically for alcoholism by a staff which works full time in that field.

XIX. PRIVATE PSYCHIATRIC HOSPITALS

There are seventeen private psychiatric institutions and two tax-supported facilities (University of Maryland Psychiatric Institute and the Veterans Administration Hospital at Perry Point) which provide care and treatment for the mentally ill. Ten of these hospitals treat alcoholic patients. Only a few of these will admit acutely ill alcoholics. Roughly the same sort of treatments as have been previously described are provided. Most of the alcoholics are in these hospitals under voluntary commitment.** No research or evaluative studies of any kind have been made. There is reason to believe that the readmission rate,

*See Appendix VII

**See Appendix VIII

while high, is not as high as that at the State Mental Hospitals. Cost of treatment may well explain part of this.

XX. PSYCHIATRIC OUTPATIENT CLINICS

A. General. There are forty-eight psychiatric outpatient clinics in the State and an additional nine in the District of Columbia, all of which serve Maryland residents. During the fiscal year 1958-1959, thirty-two of the forty-eight clinics saw alcoholics as well as patients with alcohol-related disorders.

Among the forty-eight clinics there is a wide variation in administrative organization, goals of therapy and services rendered which is more fully described in the Appendix.* Very briefly the psychiatric outpatient clinics include:

1. 17 County Clinics (operated by 14 of the Counties)
2. 3 State Mental Hospital Outpatient Clinics
3. University of Maryland Hospital Psychiatric Institute Clinics
4. Phipps Clinic, Johns Hopkins Hospital
5. Medical Department of the Supreme Bench of Baltimore City
6. Others, e.g. Mercy Hospital Psychiatric Clinic; Veterans Administration Regional Office Mental Hygiene Clinic

B. Staff and Treatment. Most of these clinics operate on a part-time basis and have a staff which, in general, includes a psychiatrist, psychologist and psychiatric social worker. In a number of the clinics, these persons are frequently not all present on a given day, since they rotate in the performance of their duties. Few of the psychiatrists are diplomates of the Board of Psychiatry and Neurology and fewer still have any special training in or special experience with the phenomenon alcoholism. Frequently, they may be first, second or third-year residents in psychiatry.

*See Appendix IX

Bluntly speaking, there is no real treatment program for alcoholics. Only 28% of those seen for alcohol-related disorders, including those being readmitted, are even placed in treatment at all.* Treatments include some, but not all, of the ones provided at the Mental Hospitals. The remainder of the alcoholics are diagnosed and referred elsewhere to such agencies and groups as the mental hospitals, other medical agencies, the courts, social work services, vocational rehabilitation agencies and Alcoholics Anonymous. There is no follow-up.

C. General Comments. The main sources of referral to the clinics are, in order of frequency, the patients' personal physicians, the courts, and the State Mental Hospitals. It is interesting to note that during the year ending June 30, 1959, although most patients referred to the clinics by private physicians were referred only for diagnostic purposes, individuals from this group showed the most improvement when and if placed in treatment. Patients referred by members of the family were most apt to be placed in treatment, however, and least apt to show improvement or as much improvement as patients referred by other sources. Only 6% of the alcoholic patients seen in all of the clinics were terminated for the reason that "further care /was/ not indicated." About one-third of the patients quit visiting the clinics after one or two trips.

Finally, although there has in the past been a notable lack of liaison between the psychiatric outpatient clinics and the State Mental Hospitals, attempts are being made to correct this deficiency. Also, a vastly improved system of record keeping has been instituted which

*See Appendix X

should make possible greater inter-clinic control of patients, many of whom in the past shopped around from clinic to clinic. Cost of seeing alcoholics is impossible to estimate. Some worthwhile research work has been done; but, considering the extensive nature of the clinic operation, it is disappointing in amount if not in quality.

D. Conclusions. From the standpoint of serving the alcoholic patient, it may be said that, in general, the clinics are inadequately staffed by people who are relatively untrained in the treatment of alcoholics, and that inter-clinic liaison is poor as is liaison with the State Mental Hospitals. In addition, the practice of failing to provide treatment for alcoholic patients may actually do more harm than is realized. As is true in so many areas of so-called therapy for the alcoholic, there is no evaluation of the relative worth of the treatment procedures that are employed. Finally, there is no uniformity of methods, goals, interests or follow-up. Although patients are noted after treatment as "improved," "not improved," or "unknown," there is no agreement as to what these terms mean.

XXI. STATE TUBERCULOSIS HOSPITALS

There are four State Tuberculosis Hospitals operated under the State Board of Health, Mt. Wilson in Baltimore County with 392 beds, Victor Cullen in Frederick County with 123 beds, Pine Bluff in Wicomico County with 65 beds and Henryton in Howard County with 290 beds. Henryton is for colored patients. In Baltimore there are the Veterans Administration Tuberculous Hospital with 291 beds and Baltimore City Hospitals which allocate 300 beds to tuberculous patients.

There is reason to believe that alcoholism and tuberculous some-

time go hand in hand, and when they do successful treatment of tuberculosis is made considerably more difficult. There is also evidence from studies made elsewhere that the large and growing group of older, unattached males in tuberculosis hospitals contains many individuals who have spent some time in jails and in mental hospitals for excessive drinking.*

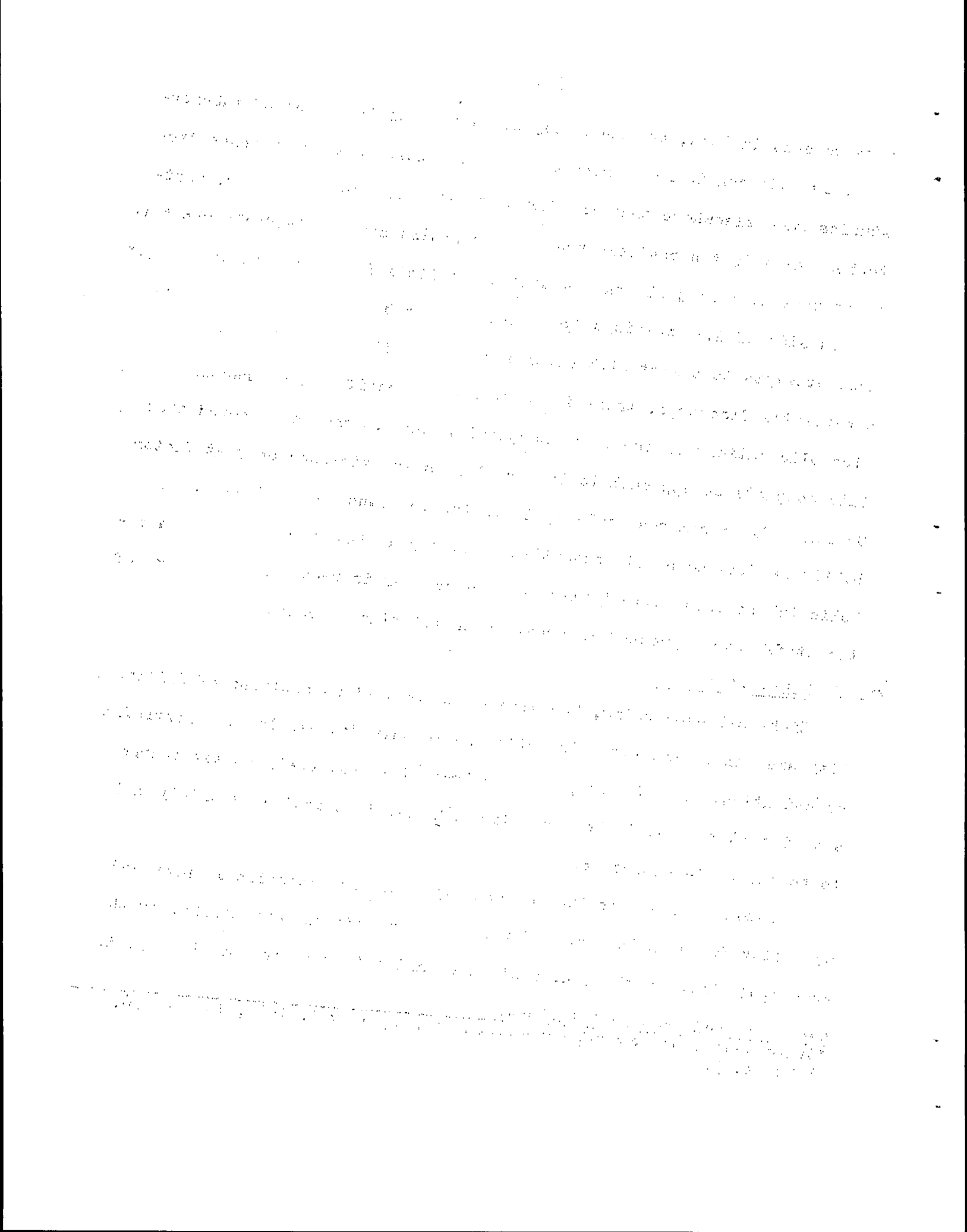
Outside of A.A. meetings being held in the hospitals, extra counseling, attempts to assist with outside social problems and attempts to plan a patient's discharge, there is no procedure specifically directed at the alcoholic patient in the State Hospitals. And it should be noted that this complete an approach to the problem is in existence only at Victor Cullen. These remarks would apply to the Veterans Hospital also. At Baltimore City Hospitals essentially nothing is being done for the alcoholic tuberculous patient although the problem is recognized and some of the staff have expressed interest in instituting a program.

XXII. HALF-WAY HOUSES

Eight self-governing, boarding homes in various sections of Baltimore City are run by the Flynn Christian Fellowship Houses, Inc., a nonprofit organization. The Houses provide a home at an extremely modest charge and attempt to assist the alcoholic individual to achieve sobriety and to become self-supporting.

A similar haven for the temporarily homeless alcoholic is provided by Valley House in Baltimore City. This project was established by the Episcopal Church with A. A. assistance and caters to men who have just been released from institutions.

*State Health Department Report, Chapter 7, July 1, 1960, to June 30, 1962, p. 5.



XXIII. GENERAL HOSPITALS

In the past all but a very few of the general hospitals have refused to accept any alcoholic patients. Of the few that did, many would treat acute alcoholics but only during their period of acute alcohol poisoning and then only in the accident room. A few others would admit alcoholics but only under the subterfuge of another diagnosis.

With certain minor exceptions these conditions remain substantially unchanged today, although with alcoholism becoming somewhat more respectable, the general hospital authorities are reluctant to state that their hospitals do not admit alcoholics.

XXIV. THE TEACHING HOSPITALS

In the teaching hospitals the same general situation prevails as was outlined in connection with the other general hospitals. The Commission would like to point out that in general the patients admitted to teaching hospitals are those who will be of use in teaching medical students and interns. It would seem that these institutions are uninterested in teaching their physicians-to-be about alcoholism.

XXV. CHRONIC DISEASE HOSPITALS

Maryland's Chronic Disease Hospitals provide an excellent program of physical restoration and rehabilitation for the chronically ill and disabled. There are three such hospitals, and they are under the jurisdiction of the State Board of Health.

These hospitals are not set up to and do not accept persons who are suffering from acute alcohol poisoning, nor do they accept persons with a primary diagnosis of alcoholism.

However, since many of the physical disabilities for which these

patients are being treated normally result from past histories of long drinking, the Commission feels that these institutions should be investigated further.

XXVI. MEDICAL CARE PROGRAM OF THE STATE DEPARTMENT OF HEALTH

The Medical Care Program of the State Department of Health administers State funds to provide personal health services and outpatient and hospital care for the recipients of public assistance in Baltimore City and in the Counties. This financial aid is also provided for the medically indigent in the Counties. In effect, the persons receiving such assistance go to their physician or the hospital and the State pays the bill.

Since there is substantial evidence that a large number of persons receiving State aid of one kind or another also have drinking problems, the Commission feels that recipients of Medical Care Program assistance should be investigated further. Data currently maintained on this group is unfortunately of no use in this regard.

XXVII. MEDICAL DEPARTMENTS OF PRIVATE INDUSTRY, LICENSED NURSING HOMES, AND BLUE CROSS

A. Medical Departments of Private Industry. Further investigation is needed in this area; but, in general, little is being done in Maryland by private industry. This is especially true when compared to efforts being exerted in other parts of the country.

B. Licensed Nursing Homes. Although only 6 out of 158 licensed nursing homes currently accept alcoholic patients, these six accept a substantial number and should be investigated further.

C. Blue Cross. The standard, current Blue Cross contract will pay

for 20 days' hospitalization for alcoholism. Of 800,000 persons covered, only 169 availed themselves of this benefit in 1959. For these individuals Blue Cross paid out $30,327 for 1,564 days hospitalization.

XXVIII. CONCLUSIONS

From the Commission's study of the medical-psychiatric facilities and procedures available in Maryland for the acute and chronic alcoholic, several points emerge. First of all, the definition of alcoholism, the methods and criteria by which alcoholics are identified and labeled, and the treatment goals all vary from one institution and agency to another and between units and persons within the same institution and agency. Secondly, although, in some instances, fairly elaborate treatment procedures are employed, there is an almost total lack of follow-up and of evaluation of the effectiveness of the various therapies used. Third, there is almost no effective coordination and liaison between the different agencies handling alcoholics. Fourth, and closely connected with this lack of coordination, is the absence of discharge planning and the failure to use or even to be aware of the existence of agencies and services in the community which might be of substantial assistance to the alcoholic patient. For example, out of the 739 patients seen by the psychiatric outpatient clinics, only three were referred to Alcoholics Anonymous. Fifth, many professional staff members have little or no training in, or even experience in, dealing with alcoholic patients. Sixth, despite the fact that excessive drinking seriously complicates treatment of the tuberculous patient, very little, generally speaking, is being done to combat alcoholism in the alcoholic TB patient. Seventh, constant readmissions are overtaxing the admission services of the State Mental Hospitals.

Almost half of the alcoholic patients in one hospital made an average of three return trips within a five-year period and 30% of the alcoholic patients in another had returned at least once within a two-year period.

PART D. CMISSIONS AND SUMMARY

XXIX. OMISSIONS

As has been pointed out earlier, in the time available, the Commission has not been able to thoroughly investigate and study all of the agencies and groups listed under Part B and Part C of this Report. For example, three Counties, Prince George's, Montgomery and Washington, have initiated and are experimenting with new, fairly substantial programs and/or approaches aimed directly at the excessive drinker. In addition, there are a number of other agencies and groups working in the field of alcoholism which were not even mentioned on these lists. These would include, among others, such organizations as the Baltimore City Health Department, Alcoholics Anonymous, and the Maryland Society on Alcoholism. The omission of detailed discussions of these various organizations does not mean that the Commission is either unaware of their existence or uninformed as to their operations. Rather they have been omitted because of the limitations of time and space. Also omitted is the problem of public education. In passing, however, it might be well to mention that Alcoholics Anonymous has had the greatest success in working with alcoholics of any organization in the State. At the other end of the scale, it is extremely interesting to note that the Baltimore City Health Department, as of a month or so ago, had included nothing in its budget

for combatting alcoholism even though this constitutes the fourth most serious national health problem and even though Baltimore City has some 40% of the State's alcoholic population.

XXX. SUMMARY

Although a substantial number of both professional and lay people have been working with diligence and enthusiasm in the field of alcoholism in Maryland, these efforts have been in general piecemeal, disparate, and uncoordinated. As a result, much time, effort and money is being spent to achieve ill-defined and unknown goals by ill-suited means. The great need is for coordination.

PART E. RECOMMENDATIONS

In view of all the foregoing, the Commission hereby recommends:

Recommendation No. 1: That the life of the Commission be extended and sufficient funds appropriated to carry out its work;

Recommendation No. 2: That the General Assembly immediately appropriate funds for and initiate a study of the current distribution and extent of the chronic police case inebriate problem in Baltimore City and throughout the State of Maryland, preferably through the use of certain designated magistrates' courts (See Page 21);

Recommendation No. 3: That the Commission on Alcoholism receive monthly reports on the results and progress of the study outlined in Recommendation No. 2;

Recommendation No. 4: That the General Assembly immediately appropriate funds for and authorize the Commission on Alcoholism or some other

body to begin planning for the rapid development of (1) a State-wide facility for unresponsive, chronic police court inebriates, (2) a counseling service for the most responsive alcoholics who come before the magistrates' courts (See Page 20), and (3) guides and procedures for the use of each and for the selection of candidates for each;

Recommendation No. 5: That the General Assembly immediately take whatever action is necessary and appropriate whatever funds are needed to insure that:

(1) The Alcoholic Unit at Spring Grove State Hospital be used to capacity and preliminary steps be taken to establish similar units in the other State Mental Hospitals;

(2) The professional and nonprofessional service staff of the Alcoholic Unit at Spring Grove State Hospital be increased to and maintained at a level sufficient to provide full, proper and efficient treatment;

(3) Adequate and intensive research be initiated and carried out to evaluate and determine the effectiveness of the various therapies (in addition to drugs) employed at Spring Grove State Hospital in the field of alcoholism;

(4) Long-term follow-up procedures be initiated at Spring Grove State Hospital to, among other things, assist the research staff in carrying out (3) above;

(5) Research at Spring Grove State Hospital be broadened to include investigation into the specific area of identification and classification of different types and/or kinds of alcoholics;

(6) The Spring Grove State Hospital research staff be augmented sufficiently to enable it to carry out the research projects above;

(7) Copies of all reports on research projects be sent to the Commission on Alcoholism.

The Commission would like to reiterate that this report is preliminary and predicated on a few months' work. As the work of the Commission

continues more complete reports and recommendations will be forthcoming.

MARYLAND COMMISSION ON ALCOHOLISM

February 10, 1961
Baltimore, Maryland

APPENDIX I

EXPLANATION OF JELLINEK ESTIMATION FORMULA

In the absence of an objective census of the number of alcoholics in any population unit, Dr. E. M. Jellinek devised an indirect method. It consists of the estimation of the number of two kinds of alcoholics--those with complications (have a diagnosable physical or psychiatric change attributable to prolonged excessive use of alcohol) and those without such complications. When these two estimates are multiplied, the total number of alcoholics is reached for a given population unit.

The number of those with complications is reached by assuming a constant relationship between the percentages of alcoholics who die of cirrhosis of the liver in any given year and the proporation of all deaths from cirrhosis assigned to alcoholism during that year.

The number of those alcoholics without complications is reached by use of a second "constant" which various from country to country. In the United States and Canada it is four; i.e., there are three alcoholics without complications for every one with complications.

Thus, in broad outline, the formula is: the total number of alcoholics alive in a given year for a specific unit equals the number of alcoholics with complications multiplied by four.

APPENDIX II

SOURCE OF DATA REGARDING PREVALENCE

See the following:

Jellinek, E. M. "Recent trends in Alcoholism and in Alcohol Consumption," Quarterly Journal of Studies on Alcohol, Vol. 8: 1-42. June 1947.

Jellinek, E. M. and Mark Keller, "Rates of Alcoholism in the United States of America, 1940-1948," Quarterly Journal of Studies on Alcohol, Vol. 13: 49-59. March 1952.

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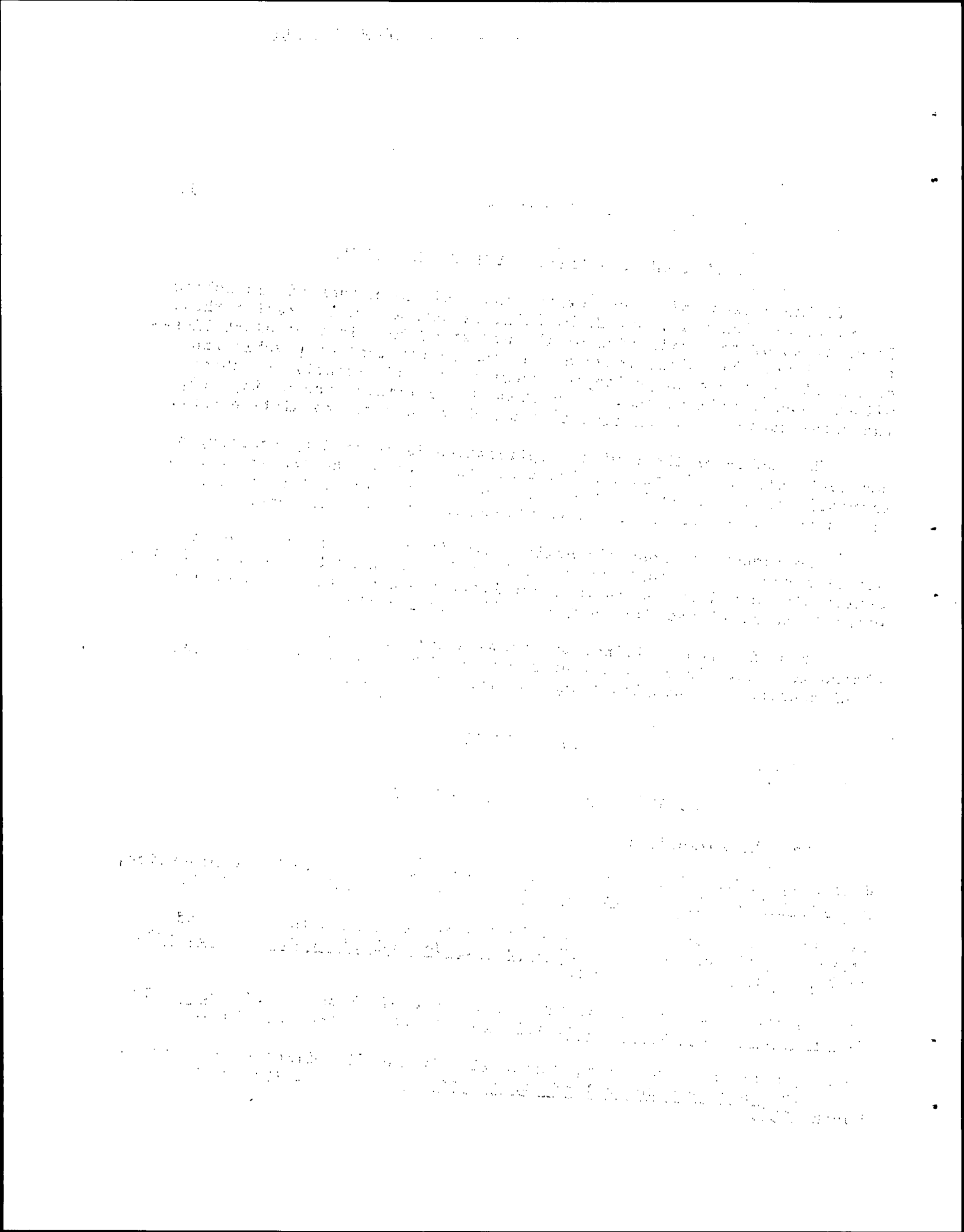

APPENDIX III

LIST OF PAST ACTIVITIES IN MARYLAND

1935 Baltimore Criminal Justice Commission: "Drunken Driving Cases in Baltimore 1934 and 1935." 1935. (Unpublished report)

1945 Seliger, Robert V., in collaboration with Victoria Cranford: A Guide on Alcoholism for Social Workers, Alcoholism Publications, The William Frederick Press, N. Y. March 1945.

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Price, Charles P.: "The Jail's Responsibility Toward the Chronic Alcoholic". Paper published in Proceedings of meeting of American Prison Assoc., Detroit, Mich. Oct. 1946. Also published in Prison World, Vol. 8, No. 6. Nov.-Dec. 1946

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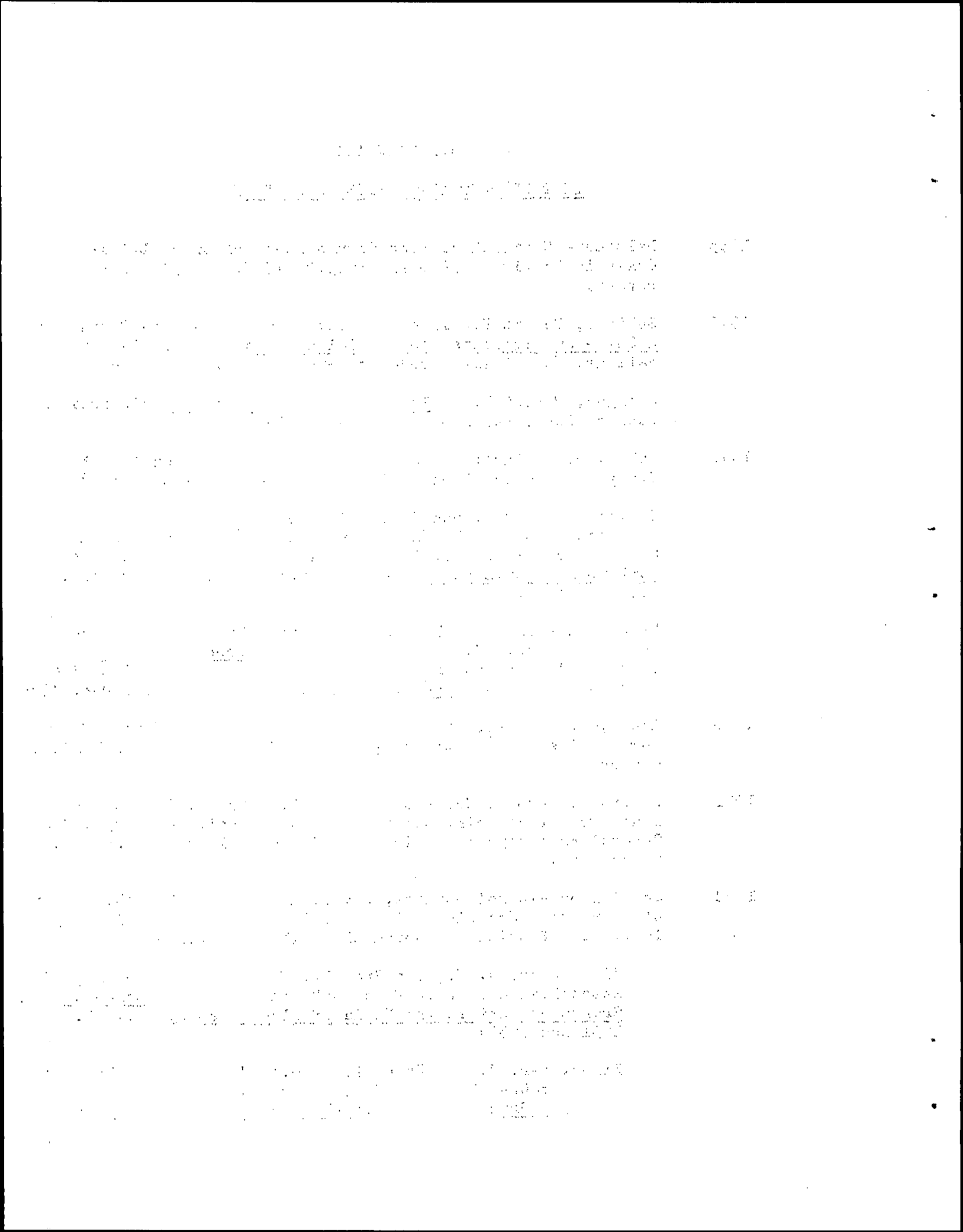
Finesinger, J. E., Grenell, R. G.: "Affects of Chemicals Upon Cerebral Oxidation", (This research was listed under Research Grants Support in the Field of Alcoholism by



N.I.M.H. for years, 1954 to 1960 inclusively.)

Freund, Julia, Gliedman, Lester H., Thomas, Robert E., Imber, Stanley D., and Stone, Anthony R.: "The Public Health Nurse and Alcoholic Rehabilitation". (Unpublished)

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Grenell, Robert F.: "Alcohols and Activity of Cerebral Neurons", Quarterly Journal of Studies on Alcohol, Vol. 20: 421-427.

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National Association of Social Workers, Vol. 41, No. 1, pp. 33-38. January 1960.

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Padula, Helen, Chief Supervisor, Social Service Department: "A Study of Movement of Patients in Spring Grove State Hospital". August 1956. (A memorandum to Dr. Isadore Tuerk)

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Maryland Statutes Dealing with Alcoholics

Art. 16 - "Inebriates"

Art. 16:43 - "Commitment of Habitual Drunkards, Including Voluntary Commitment"

Anyone alleged by petition under oath to be an habitual drunkard, unable to care for self or property, may be arrested by sheriff and brought before County or Baltimore City Circuit Court; a jury empanelled according to 16:134 shall decide in his presence whether he is a drunkard and unable to care for himself; the proceedings shall be like those for persons alleged to be insane; rules and proceedings now applicable to lunatics' property shall apply; any such alleged habitual drunkard may dispense with legal proceedings and, with court's approval, appoint his own committee and voluntarily enter any institution selected by the court for a limited time to be retained there for that agreed length of time. A person found by jury (involuntarily) to be an habitual drunkard, unable to care for himself, shall have a committee appointed by the court, who may have power to confine him to an institution for whatever time court approves in writing; with the court's written approval committee may release him from confinement, and the period of confinement may be extended from time to time, "for such period as may be necessary for his complete reformation"! An habitual drunkard: anyone habitually addicted to alcohol, opium, cocaine, morphine, or any other intoxicant.
(188, ch. 71)

Art. 16:44 - Medical Treatment of Habitual Drunkards--Petition for

Any relative or friend of an habitual drunkard may petition the County or Baltimore City Circuit Court where he resides for leave to send him, at the expense of the County or City, to "such institution for the medical treatment of drunkenness" as court may designate; petition must state his name, age and "condition" and specify that neither he nor petitioners are financially able to pay for his cure; the petition must also state that he will agree "to attend such institution for the cure of drunkenness"; the petition is to be verified and contain the habitual drunkard's written agreement to take treatment and obey the rules of the institution administering it, along with the names of three taxpayers of the County of his residence (or Baltimore City) stating that they are familiar with the facts set forth in the petition and with the financial circumstances of the drunkard and his petitioning kin, and think it a proper case for public assistance.
(1894, ch. 247, par. 1)

Art. 16:45 - Medical Treatment of Habitual Drunkards--Sending to Institutions; Payment.

Any drunkard, resident of a County (or Baltimore City) for six months and desiring to be treated, may be sent to some institution for

the cure of drunkenness by a Circuit Court provided that the institution's managers agree to treat him at a cost to the County not exceeding $125 a year; the court shall not be compelled to send him to an institution making a lower bid, unless his best interests shall be promoted; the judge shall order the expense to be paid out of the County or City Treasury in the same manner as other claims for the administration of justice; no County or Baltimore City shall be required to send the same habitual drunkard to any institution for medical treatment a second time at its expense.
(1894, ch. 247, par. 2)

Art. 16:47 - Medical Treatment of Habitual Drunkard--Officers of Institutions

Officers of institutions for treatment shall be sworn officers of the committing court with powers to enforce rules for administering treatment, but with no fee other than the $125 max.
(1894, ch. 247, par. 4)

Art. 16:48 - Medical Treatment of Habitual Drunkards--Meaning of Drunkard

"A drunkard * * * (is) any person who has acquired the habit of using spirituous, malt or fermented liquors, cocaine, or other narcotics to such a degree as to deprive him of reasonable self-control."
(1894, ch. 247, par. 5)

Art. 16:49 - Committing Person Charged with Criminal Offense

Anyone charged with committing a crime and shown to be suffering from acute or chronic alcoholism, may be committed to a state hospital for treatment and observation under terms and conditions to be determined by the judge; such commitment may be made only by a judge of the Supreme Bench of Baltimore City or of a County Circuit Court.
(1945, ch. 517)

Art. 16:50 - Baltimore City - Maximum Appropriation

The Mayor and City Council of Baltimore are not obliged to appropriate more than $3,000 a year for the care of inebriates.
(1914, ch. 117)

Art. 16:134 - Determination of Sanity

The use of a sheriff's jury to determine sanity is abolished. Upon filing a petition de lunatico inquirendo sanity is to be determined by the County or Baltimore City Circuit Courts in equity. The jury shall be empanelled from jurors in law or criminal court in the City or County; if none in attendance, court shall select 20 men from

the last jury term. Summoning and empanelling jury shall proceed in accordance with rules and practice in other civil cases.
(1947, ch. 751)

Article 59, "Lunatics and Insane"

Art. 59:1 - Commitment of Incompetent with No Means of Support

Anyone alleged to be insane and without sufficient means (and without legally chargeable relatives) may be confined by County Commissioners or Baltimore DPW, upon written request of two qualified physicians (in accordance with Sec. 31) in a hospital or some other place better suited to his condition, at the expense or partial expense of the County or City (as provided in Sec. 5* and 44**) until he shall have recovered and be discharged * * *. If a jury trial is demanded by the alleged lunatic, his relative, friend, County Commissioners or Baltimore DPW, then County Circuit Court or Baltimore City Criminal Court shall empanel a jury (as prescribed by Article 16:134), charge it to inquire of the alleged insanity and commit the patient as above if the jury find him insane. If County Commissioners or Baltimore City DPW are not satisfied that someone brought before them for commitment is insane, they must notify the State's Attorney who shall bring the "said question" (insanity) before the County Circuit Court or Baltimore City Criminal Court for determination. "Nothing contained in this section shall prevent the friends or relatives of such lunatic or insane person from confining him or providing for his comfort".
(1834, ch. 194)

* Sec. 5 sets the rates for maintenance and orders investigation of financial condition.

** Sec. 44 prescribes how local authorities are to share payments with the Department of Mental Hygiene.

Art. 59:21 - Determination of Sanity by Court or Jury

Anyone confined in state or private institution or anyone on his behalf, including superintendent, may file petition in the County or Baltimore City law courts, either where he is confined, or from which he was committed or which was his bona fide residence when committed requesting that he be brought before the court for the purpose of having his sanity determined; jury trial may be had. Anyone in interest may compel attendance of witnesses. If determined to be insane he shall be recommitted, otherwise discharged. After one such hearing, any further petition must be accompanied by affidavits purporting to show improvement in his mental condition since last hearing. The court shall pass on these affidavits and dismiss the petition unless satisfied that they show a substantial improvement.
(1920, ch. 682)

Art. 59:31 - Physician's Certificate before Commitment

No commitment shall be made to any institution, public or private, except upon written certificates of two qualified physicians of Maryland made within one week after separate examination and setting forth the insanity and reason for their opinion. No certificate good for more than 30 days after examination.
(1886, ch. 487)

(Form of Certificate Prescribed)

This section shall not apply to cases of voluntary commitments under Sec. 37.

Art. 59:32 - Commitment on Request of Member of Family, Relative, Friend.

Anyone certified as insane by two doctors (Sec. 31) may be received and retained as a patient in a state or private insitution upon written request of a member of his family, near relative or friend, or person with whom he resides, or the officer of a charitable institution or agency; provided that the petitioner may request discharge in writing which shall be complied with unless the superintendent thinks further detention is required--in this event the superintendent shall retain custody and file petition in the County or Baltimore City law courts to have sanity determined. If the court shall commit him, he shall be confined until he recovers or is discharged in due course of law. "The provisions of this article relating to the discharge of recovered patients and to the expense of maintaining them in state institutions shall be applicable to persons entering such institutions under the provisions hereof".

Court costs arising from a Sec. 32 proceeding are to be paid by the alleged insane person if he has "property or estate"---if not, then by the County (or Baltimore City) (a) responsible for his maintenance, or (b) in which he had his residence before confinement.
(1944, sp. sess., ch. 14, par. 34A)

Art. 59:37 - Admission and Detention of Voluntary Patient

Anyone who desires treatment and applies therefor in writing, at own expense or that of relatives or friends or of the County upon consent of County Commissioners or of Baltimore DPW may be received and detained in institution or hospital. He shall not be detained more than three days after giving notice unless legally committed meantime in accordance with Sec. 31; nor shall anyone be received or detained as a voluntary patient who is unable to understand voluntary commitment, or request his discharge, or give continuous assent to his detention. Every patient voluntarily admitted shall be reported to the Department of Mental Hygiene as in legal commitments and further reported every three months "and when discharged a copy of this section

shall be read or exhibited to every person requesting admission to any institution in accordance with its provisions".
(1886, ch. 487, par. 38)

Art. 59:38 - Attendant Physician Required

No public or private institution for the insane, shall hold in confinement any insane person "for compensation" without having a physician in regular attendance.
(1886, ch. 487, par. 39)

Art. 59:42 - Discharge of Patients

Any patient, except one under a criminal charge, may be discharged when superintendent is satisfied by personal examination that he has recovered. He may also be discharged if appearing quiet and harmless and not likely to improve, providing superintendent is satisfied that relatives or friends can give him proper care and supervision. No patient believed dangerous to self and others may be discharged except upon court order. Nothing herein shall prevent relatives or friends of a patient maintained by them from removing him at any time, but in the event of such removal, when the superintendent believes the patient to be dangerous, it shall be his duty to so advise the relatives or friends in writing, and file a copy of such notice with the court papers.
(1910, ch. 715, par. 380)

CRIMINAL STATUTE

Art. 27:123 - Drunkenness and Disorderly Conduct Generally; Habitual Offenders.

Being found drunk, or "acting in a disorderly manner to the disturbance of the public peace" on a street or highway, or public resort, church, store, elevator, lobby, corridor or apartment house with more than three units, is a misdemeanor punishable by a $50 fine or 60 days in jail or both. "Habitual offenders may be fined not more than $100 or committed to jail or house of correction for six months maximum. An habitual offender is a person who shall have been convicted under the provisions of this section five (5) times in the preceding twelve (12) months." County Trial Magistrates shall have concurrent jurisdiction with County Circuit Courts; Baltimore City Police Magistrates shall have concurrent jurisdiction with Criminal Court.
(1892, ch. 672)

Summary of Data Collected at Maryland House of Correction

The following institutions are under the jurisdiction of the Department of Correction:

Institution	Type	Rated Normal Capacity	Present Population
Penitentiary	Maximum Security	998	1,511
House of Correction	Medium Security	1,505	1,954
Reformatory for Males	Minimum Security	658	1,111
Reformatory for Women	Minimum Security	204	162
Patuxent	Defective-- Indeterminate Sentence	388	287

Originally it was decided to review the individual file folders on each white inmate between the ages 45 to 60 at the House of Correction in order to determine whether or not sufficient information was normally included so as to enable classification of inmates by alcohol problem from this source alone. It had early been decided that there was insufficient time to conduct individual interviews and that this by itself would be a relatively unprofitable undertaking in any event.

Accordingly, the file folders were reviewed for each white inmate born in the years from 1900 through 1915, inclusive. This was done with the following results:

117 Total Inmates (45-60)
18 Files not checked*
99 Files reviewed
59 Definite alcohol problem

From this review it was found that the files were not uniform and that no classification of excessive drinking could be made. It was discovered, however, that there was sufficient significant reliable information in the files of this group to indicate that a large percentage of them had drinking problems of marked severity.

Therefore, it was decided to enlarge the sample to include all white males from age 30 to 45 in an effort to determine whether or not a large segment of this enlarged group had drinking problems. Accordingly, the files were investigated for each white inmate born in the years 1916 through 1930 with the exception of the files on 42 inmates. Most of the 42 not checked were new arrivals; and, therefore, their folders had not been placed in the main filing cabinets at the time of investigation. However, they were not investigated because

*These file folders were not checked because at the time of the investigation they were not in the filing cabinet but instead were in use by the staff at the House of Correction.

of lack of time resulting in part from bad weather and, on one occasion, lack of availability of working space. Finally, because of inadequacies in the survey method and results it was decided that nothing could be gained by completing the investigation of these 42 files. The results follow:

330	Total Inmates
24	Files not checked*
42	Unchecked (for reason outlined above)
66	Total unchecked
264	Files reviewed
92	Definite alcohol problem

The racial breakdown for total commitments to the House of Correction for fiscal year 1960 is:

4,163	Committed
2,470	Negro
1,693	White
59.3%	Negro

Dr. George F. Fitzgibbon, Director of Correctional Classification and Research, Maryland Department of Correction, has indicated that in his years of connection with the House of Correction the ratio of negro to white has usually been a little better than 6 to 4. He feels that the population at the House of Correction is generally about 60% to 65% negro.

During the investigation no record was made of the offenses for which the inmates had been incarcerated, although this was noted in a number of cases. However, the investigators gained the definite impression that the majority of the individuals in the 45 to 60 group with drinking problems had had long, flagrant histories of excessive drinking and arrests for drunkenness. In addition they had been incarcerated for generally less violent and odious offenses. A number had been sentenced for such things as false pretense, forgery, petty larceny, nonsupport, habitual drunkenness. Few, if any, had ever served in the Armed Forces. They seemed to be the late stage skid row drunks.

The younger men in the 30-45-year-old age bracket had definite alcohol problems but they also had less arrests for drunkenness and less of them had such histories. Drinking had resulted in family disruptions, job problems, and bad discharges from the services. In addition, they had long criminal histories involving more serious crimes. They appeared to be, as a group, headed either for skid row at some time in the future or a lifetime in high security penal institutions.

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* These file folders were not checked because at the time of the investigation they were not in the filing cabinet but instead were in use by the staff at the House of Correction.

APPENDIX VI

Suggested Form for Use by Magistrates

For All Cases of (1) Drunkenness, (2) Disorderly Conduct, (3) Disturbing the Peace, (4) Begging, (5) Vagrancy, (6) Assault

Jurisdiction _____
Docket # _____
Date _____
Offense Charged _____

Age ____
Male ____ White ____
Female ____ Negro ____

(1) Did this offense result from the use of alcohol? Yes ___ No ___

(2) Has defendant a prior arrest record for the above 6 offenses?
(A) Is it
Long (10 arrests or more) ___
Medium (5 to 10 arrests) ___
Short (1 to 5 arrests) ___

(3) Has defendant had drinking problem
for long period of time (10 years or more) ___
for medium period of time (5 to 10 years) ___
for short period of time (1 to 5 years) ___
NOT AT ALL (0) ___

(4) Has defendant been on skid row
for long period of time (10 years or more) ___
for medium period of time (5 to 10 years) ___
for short period of time (1 to 5 years) ___
NOT AT ALL (0) ___

(5) Does defendant have a job:
(A) Has he had one within the past six months?
Yes ___ Perm. ___
No ___ Temp. ___
Yes ___ Perm. ___
No ___ Temp. ___

(B) What sort of work did defendant do? (Ex. dishwasher, car salesman, laborer, etc.) _____

(6) (A) Has defendant
Home ___
apartment ___
relative, or friends with whom he lives ___
none of above ___

(B) Is defendant
married ___
separated ___
divorced ___
widowed ___
single ___

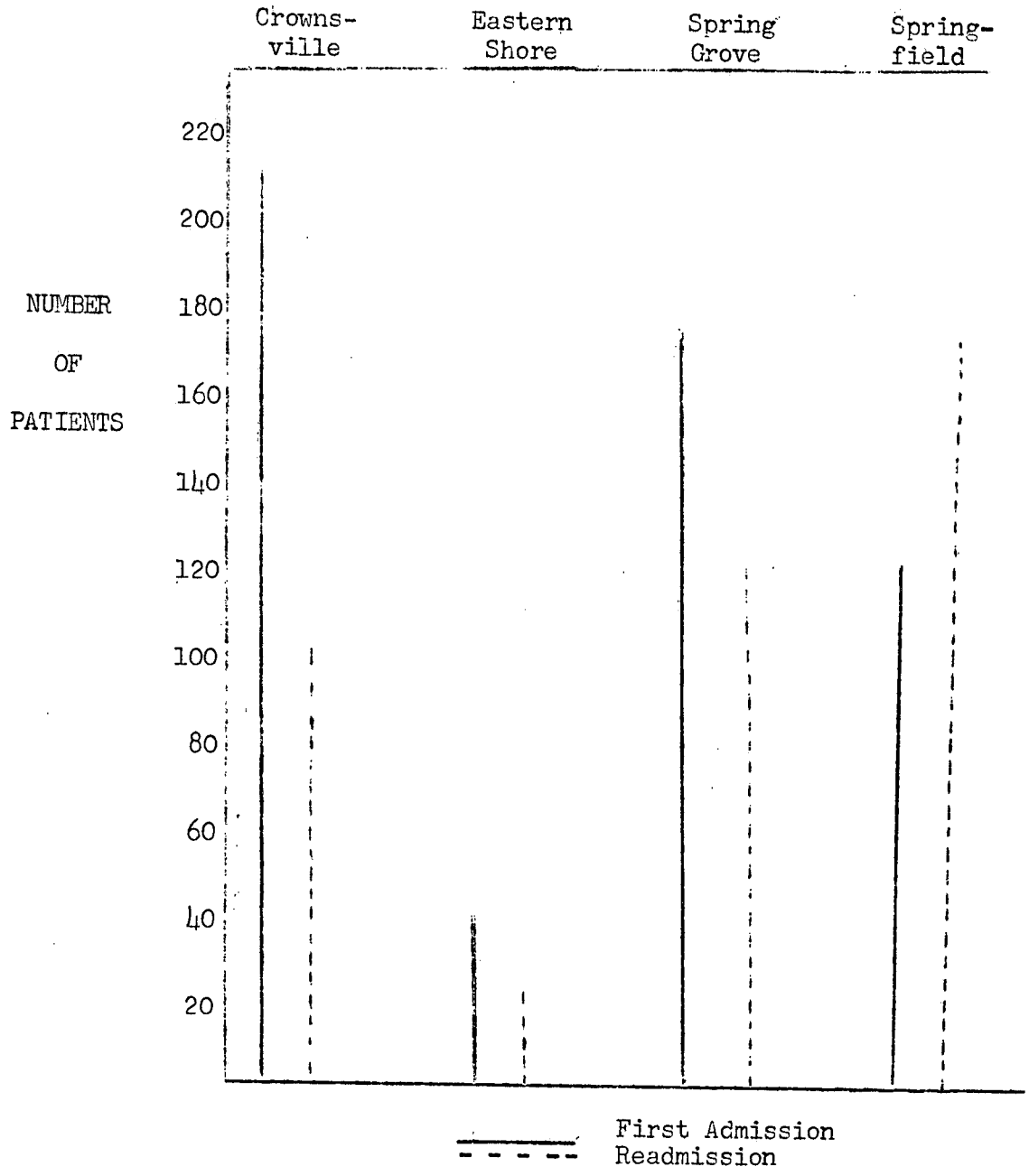
(C) Does defendant have any resources?
Yes ___
No ___

(7) Do you believe defendant
(A) Desires to be rehabilitated? Yes ___ No ___
(B) Could be rehabilitated? Yes ___ No ___

APPENDIX VII

First Admissions and Readmissions of Alcoholic Patients to State Mental Hospitals

1959



APPENDIX VIII

Brief Description of Typical Private Psychiatric Hospital Treating Alcoholics

The following general description is a composite picture and is typical of the average private psychiatric hospital treating alcoholic patients.

The institution, which is licensed by the Department of Mental Hygiene for the care and treatment of the mentally ill, admits both acute and chronic white alcoholics for treatment. Many of these patients are still regularly employed and still have strong family ties. For the most part treatment consists of "drying-out" the alcoholic in the acute phase of the illness. No studies of the results of therapies used have been reported.

Information was available on 109 alcoholic patients out of the 134 discharged during the year ending June 30, 1960. Out of this group of 109, 72 were admitted for the first time which is a much higher percentage of first admissions than is to be found in the State Mental Hospitals. In addition, over 80% of these first admissions were voluntary.

The medium age on admission for all patients both male and female in this group was between 45 and 49. Males made up 75% of the group. Over 77% of the patients were married; six had never been married; one was a widower; and the marital status of one was unknown.

On the average the patients spent 14 days in the hospital for each admission. The total days in the hospital for the group was 1,568. The cost of each hospitalization at a daily Blue Cross reimbursement rate of $12.00 amounted to $171.48.

A Description of Psychiatric Outpatient Clinics in Maryland and Various Statistical Tables

From 1911, when Dr. Adolph Meyer, as Chairman of After Care Committee of the Maryland Psychiatric Society, first enlisted the services of volunteers to assist individuals discharged from state mental hospitals to return to their homes, numerous psychiatric outpatient clinics have been developed under a variety of auspices throughout the State. Very few people were aware of the existence of many of these clinics and of the fact that there are 48 clinics serving residents of Maryland until 1959 when data from these 48 clinics were assembled on IBM cards under the very able direction of Dr. Anita E. Bahn, staff member of the National Institute of Mental Health, in preparation of her Sc.D. dissertation entitled "A Methodological Study of the Outpatient Clinic Population of Maryland."

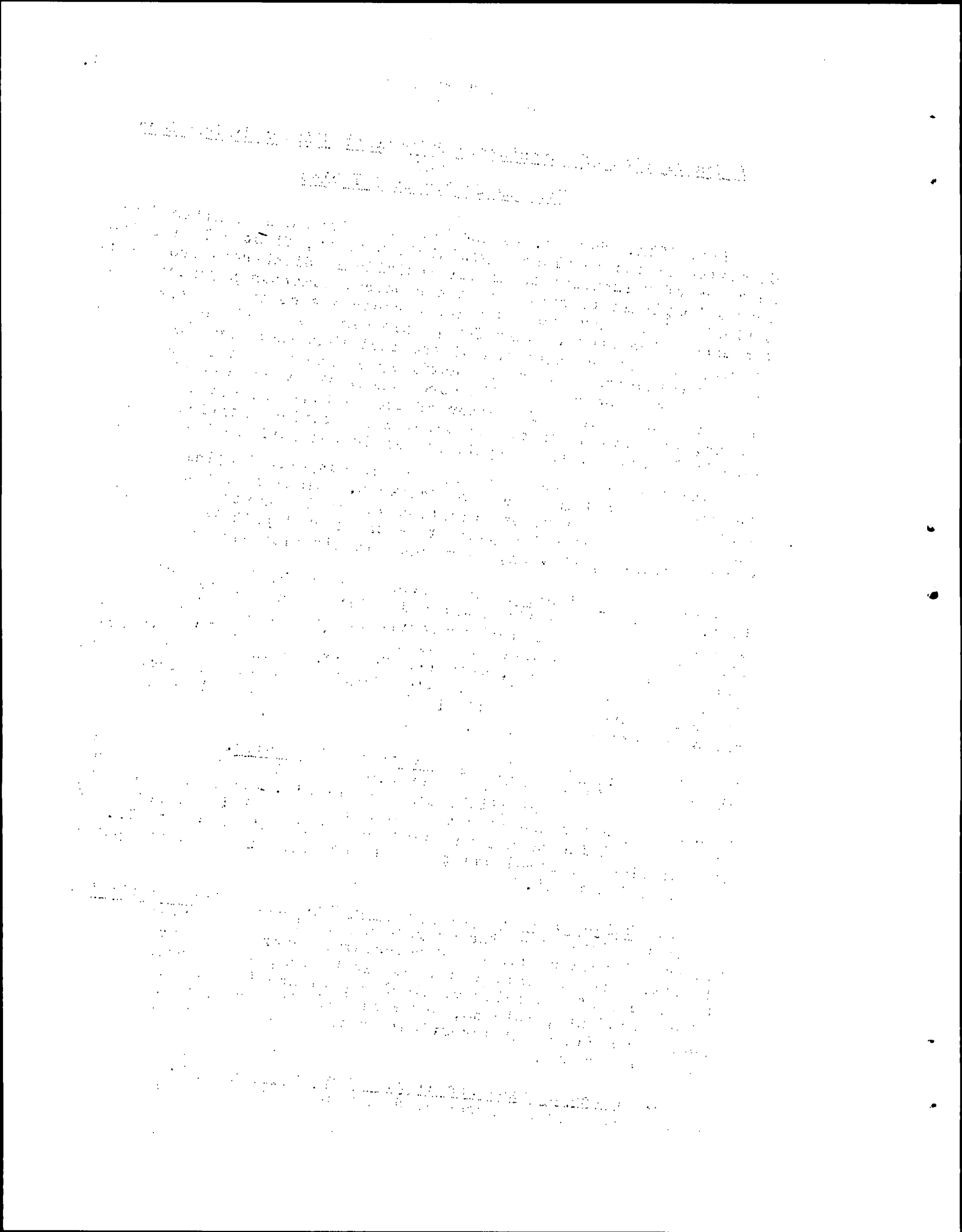
Thirty-two of these 48 psychiatric outpatient clinics saw patients who were reported as excessive drinkers. Because of the wide variation in administrative organization and in the goals of therapy and services rendered to the patients with alcohol pathology among the various clinics, they may be grouped in six classifications:

A. County Clinics. The State Board of Health is designated (Art. 43, Sec. 44 of the Annotated Code) as the agency of the State to administer a program of noninstitutional services for the mentally ill within the 23 counties. Fourteen of these counties (Allegany, Anne Arundel, Baltimore, Carroll, Charles, Dorchester, Frederick, Kent, Montgomery, Prince George's, Saint Mary's, Talbot, Washington and Wicomico) were operating 17 clinics reporting patients classified as excessive drinkers in 1959. No fee is charged.

B. State Mental Hospital Outpatient Clinics. Three separate clinics operate under the supervision of staff members from Crownsville, Spring Grove and Springfield State Hospitals. These clinics provide a pre-admission service to patients, members of their family and community agencies desiring to use the services of the State Hospitals. They also provide a post-discharge treatment program. Patients pay nothing for their treatment.

C. University of Maryland Hospital, Psychiatric Institute. The Institute administers the Comprehensive Clinic, Psychiatric Adult Clinic, Alcoholic Clinic and Psychiatric Emergency Service. These clinics, each of which also sees alcoholics, are organized mainly for the purpose of providing clinical experience for junior and senior medical students, interns, and residents in psychiatry. Each patient undergoes a financial investigation to determine rate of payment for each clinic visit.

D. Johns Hopkins Hospital, Henry Phipps Clinic. Persons diagnosed as alcoholics or as excessive drinkers are seen in the Adult Psychiatric



Clinic in accordance with the Charter of the Johns Hopkins Hospital which was established "to treat the sick poor of East Baltimore" and to provide clinical experience for students in the Johns Hopkins Medical School. The Phipps Clinic therefore has a dual purpose. The Clinic serves patients who are able to pay the fee set by the financial investigator or persons who are recipients of public assistance whose care is reimbursed by the City. The Hospital is also reimbursed for treating residents of surrounding counties who are recipients of public assistance or who are certified by the county health department as medically indigent.

E. Supreme Bench, Medical Department. Judges of the Supreme Bench in Baltimore City may refer court cases to the Medical Service for examination and recommendation. Patients are referred elsewhere for treatment.

F. Other Psychiatric Outpatient Clinics. These clinics include the Mercy Hospital Psychiatric Clinic, Veterans Administration Regional Office Mental Hygiene Clinic, and Washington, D. C. Clinics serving Maryland residents, such as the Veterans Administration Regional Office Mental Hygiene Clinic in D. C. and the Georgetown Adult Psychiatric Clinic.

APPENDIX IX (contd)

TABLE 1

NUMBER OF EXCESSIVE DRINKERS (INCLUDING READMISSIONS) DISCHARGED FROM PSYCHIATRIC OUTPATIENT CLINICS BY SOURCE OF REFERRAL AND BY TYPE OF SERVICE AND CONDITION AFTER TREATMENT DURING YEAR ENDING JUNE 30, 1959

	Received Treatment				Treatment Not Given					
Referred by	Imp.	Not Imp.	Cond. Unkn.	Total	Psy-chi.	Psy-cho.	Other	Total	Ser. Unk.	Tot.
Self	9	14	8	31	59	0	6	65	0	96
Family, relative, friend	5	19	7	31	32	1	2	35	2	68
School	0	0	0	0	0	0	0	0	0	0
Health Dept.	1	1	0	2	6	0	1	7	0	9
Physician or Gen. Hosp.	21	22	1	44	132	1	3	136	0	180
Outpat. Psychiatric Ser.	3	0	3	3	8	0	1	9	0	12
Inpat. Psychia. Fac.	17	30	9	56	41	0	1	42	23	121
Social Agcy.	11	12	2	25	45	1	3	49	0	74
Court	6	6	2	14	142	3	4	149	0	163
V. A.	0	2	0	2	2	0	0	2	0	4
Unknown	3	8	0	11	0	0	0	0	0	11
Total	76	114	29	219	468	6	21	495	25	739

TABLE 2

NUMBER OF EXCESSIVE DRINKERS (INCLUDING READMISSIONS)
DISCHARGED FROM COUNTY MENTAL HEALTH CLINICS
BY COUNTY AND TYPE OF SERVICE
AND CONDITION AFTER TREATMENT
DURING YEAR ENDING
JUNE 30, 1959

County Clinic	Received Treatment				Treatment Not Given				Ser. Unk.	Total
	Imp.	Not Imp.	Cond. Unkn.	Total	Psy-chi.	Psy-cho.	Oth.	Total		
Allegany	1	1	1	3	12		2	14		17
Anne Arundel	2		1	3	2			2		5
Baltimore	4	7	12	23	3		8	11		34
Carroll	1			1	3			3		4
Charles				0	2	2		4		4
Dorchester	1			1	1			1		2
Frederick				0	2	1	2	5		5
Kent				0	1			1		1
Montgomery	10	5		15	6	2	3	11		26
Prince George's				0	4		1	5		5
St. Mary's				0	1			1		1
Talbot		1		1	2			2		3
Washington	4	3		7	11	1		12		19
Wicomico	3	4		7	1			1		8
Total	26	21	14	61	51	6	16	73	0	134

TABLE 3

NUMBER OF EXCESSIVE DRINKERS (INCLUDING READMISSIONS)
DISCHARGED FROM PSYCHIATRIC OUTPATIENT CLINICS
BY CLINIC GROUP AND DISPOSITION
FOR YEAR ENDING
JUNE 30, 1959

Disposition	County Clinics	State Hosp. Clinics	Phipps	Un. of Md. Hosp.	Supreme Bench-Med.	Oth-er	Total	% of Total
Patient Withdrew	72	71	39	42	0	21	245	33.1
Further Care Not Indicated	7	25	6	6	0	0	44	5.9
" " "	7	4	9	31	2	2	55	7.4
Referred Elsewhere: Mental Hospitals	18	19	10	92	46	5	190	48.4
Other Medical	6	7	8	37	11	5	74	
Court	15		1	2	48		66	
Social Agency	3	9	3	0	6		21	
Psychological Agency				1			1	
Alcoholics Anonymous	1				2		3	
Other				3	4		7	
Unknown	5	23		2	3		33	5.2
TOTAL	134	156	76	216	122	33	739	100%

APPENDIX X

NUMBER OF EXCESSIVE DRINKERS (INCLUDING READMISSIONS)
DISCHARGED FROM PSYCHIATRIC OUTPATIENT CLINICS
BY CLINIC GROUP, TYPE OF SERVICE
AND CONDITION AFTER TREATMENT
DURING YEAR ENDING
JUNE 30, 1959

Clinic Group	Received Treatment				Treatment Not Given				Ser. Unkn.	Total	% Rec'd Treat.
	Imp.	Not Imp.	Cond. Unkn.	Total	Psy-chi.	Psy-cho.	Oth-er	Total			
County Clinics	26	21	14	61	51	6	16	73	0	134	45%
State Hosp. Clinics	20	33	1	54	66		2	68	36	158	34%
Phipps	8	21	0	29	47			47	0	76	38%
Univ. of Md. Hosp.	10	24	4	38	176			176	2	216	18%
Supreme Bench Med.				0	122			122	0	122	0%
Other	12	15	0	27	5		1	6		33	80%
Total	76	114	19	209	467	6	19	492	38	739	28%